Partnering for Success:

The 1915 (b)/(c) Medicaid Waiver

Initial DHHS Strategic Implementation Plan

July 1, 2011 – June 30, 2013

Session Law 2011-264, Section 1.(k)

"Responsible Change to Achieve Easy Access, Better Quality and Personal Outcomes"

October 19, 2011

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Chapter 1. Introduction

S.L. 2011-264, House Bill 916,[1] instructs the Department of Health and Human Services (Department) to proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing public resources that may become available for mental health, intellectual and developmental disabilities and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources.

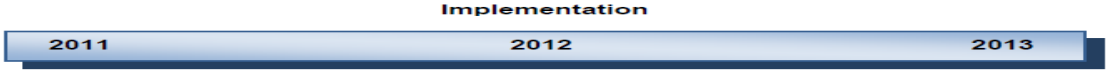
Further, S.L. 2011-264 instructs the Department in coordination with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the Division of Medical Assistance (DMA), local management entities (LMEs), and Piedmont Behavioral Health (PBH) and with stakeholder input to submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in the act.

This report presents the initial strategic plan and outlines the objectives, action steps and activities that will be accomplished over the next two years – that is state fiscal year 2012 and state fiscal year 2013. This report should be considered an initial plan that will evolve and be modified over time, experience, and with stakeholder involvement. The Department through DMH/DD/SAS and DMA will monitor, evaluate and report the status and progress on the strategic plan's objectives per legislative requirements.

Background

At the local level, DMH/DD/SAS oversees mental health, developmental disabilities and substance abuse services through a network of 23 area authorities / county programs that cover the state's 100 counties. As a result of system reform undertaken in 2001, the role of area authorities / county programs changed from service providers and managers to exclusive service managers as they became LMEs. The DMA has a specific memorandum of agreement (MOA) with DMH/DD/SAS and contracts with the LMEs. Through these MOAs and the contracts with DMA, the DMH/DD/SAS and LMEs endorse and monitor providers of Medicaid-funded mental health, developmental disabilities and substance abuse services. LMEs also develop community capacity for state-funded services through service provider contracts. The LMEs develop partnerships with formal and informal community organizations and engage service recipients and family members in planning and policy

[1] The legislation is shown in full in Appendix A.



implementation for both state and Medicaid-funded services. The Division of Medical Assistance has specific contracts with those LMEs that also perform Medicaid and Health Choice utilization review functions. LMEs develop community capacity through service provider contracts, expand partnerships with formal and informal community organizations and engage service recipients and family members in planning and policy implementation. Services are provided through the private sector.

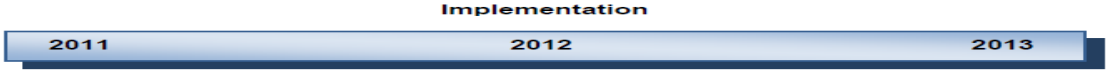
In the process of reform, the Department established one LME as a pilot Medicaid-managed care vendor through the use of 1915(b) and 1915(c) Medicaid Waivers to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid. Thus, while remaining responsible for state allocated funds including federal block grants and for all applicable rules and policies, Piedmont Behavioral Health also began managing Medicaid State Plan funded mental health and substance abuse services through the Piedmont Cardinal Health Plan. The Piedmont Cardinal Health Plan operates under a capitated model known as a pre-paid inpatient health plan (PIHP) since it includes coverage for inpatient services.

PBH also began managing Home and Community Based Services and supports through the Innovations Waiver, a 1915(c) Medicaid Waiver for individuals with intellectual or developmental disabilities. The Innovations Waiver replaced the State's Comprehensive and Supports waivers in the PBH catchment area. Accordingly, PBH assumed risk for Medicaid-funded mental health and substance abuse services (including inpatient, clinic option and rehabilitation option services) through the Piedmont Cardinal Health Plan, and for Home and Community Based Services under the Innovations Waiver. PBH has operated as a Medicaid managed care organization in Cabarrus, Davidson, Rowan, Stanly, and Union counties since April 1, 2005. All Medicaid recipients in those counties that are included in eligibility groups covered under the 1915 (b)/(c) waiver were mandatorily enrolled with PBH on April 1, 2005.

The General Assembly has supported the expansion of the PBH demonstration. S.L. 2008-107 required DHHS to study the statewide expansion of the 1915 (b)/(c) Waiver and the development of a consolidation plan for the LMEs. S.L. 2010-31 required DHHS to select two additional waiver sites for expansion.

Since the inception of the waiver programs, North Carolina has demonstrated that the State can provide quality mental health, developmental disabilities and substance abuse services through private and public sector cooperation and at a lesser or comparable cost than the fee-for-service program costs for the Medicaid eligible population.

In 2009, the Department initiated a collaborative effort with DMA and DMH/DD/SAS, and in partnership with the LMEs, to restructure the management system for Medicaid funded mental health, substance abuse and developmental disabilities services. This new management system was to build on the PBH Waiver experience with the intention to phase in the managed care model statewide. Significantly, this expansion recognized and valued the importance of a publically managed system, ensuring local presence and public accountability to respond to



the unique needs of local communities. It further assured that federal, state, and local funding resources would be managed as a single system. Responsibility within DHHS for the implementation of this new system is as follows:

- DMA manages North Carolina's Medicaid health insurance program for low-income individuals and families including parents, children, seniors, and people with disabilities. The Medicaid program includes coverage of mental health, developmental disabilities and substance abuse services. The DMA Behavioral Health Section, Clinical Policy and Programs is responsible for the oversight of all Medicaid and Health Choice-funded services. This responsibility includes oversight of the Medicaid and Health Choice budgets, State plan service development, and Centers for Medicaid and Medicare (CMS) approval of all State Plan services and 1915 Waivers for mental health, developmental disabilities, and substance abuse services. CMS holds DMA responsible for the monitoring all Medicaid funded services according to federal law outlined in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulation. Monitoring and accountability are discussed in Chapter 4.

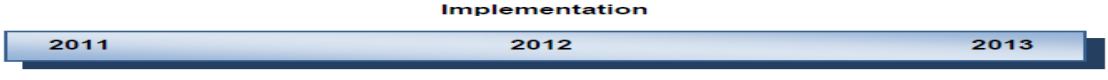
- DMH/DD/SAS has specific responsibilities for the provision of publicly funded services for individuals in North Carolina with mental health and substance abuse problems and/or with intellectual or developmental disabilities. Furthermore, DMH/DD/SAS is responsible for the programmatic oversight of the use of state funds allocated by the General Assembly for these purposes, including those provided by federal block grants.

- Both DMA and DMH/DD/SAS are Divisions with the Department of Health and Human Services. As such, the Secretary of DHHS has the ultimate responsibility to manage the waivers.

A Managed Care System

Title XIX of The Social Security Act (Act) authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose and distinct requirements. Section 1915(b), Managed Care/Freedom of Choice Waivers, allows states to implement managed care delivery systems, or otherwise limit individual's choice of provider under Medicaid. Section 1915(c), Home and Community-Based Services Waivers, allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in an institutional setting.

Title 42 of the Code of Federal Regulations (CFR) outlines the programmatic and quality guidelines for Medicaid managed care programs. DMA outlines these federal requirements for the LMEs operating as Managed Care Organizations (MCOs) and DMA is responsible for ensuring that these federal requirements are met. The federal Centers for Medicare and



Medicaid (CMS) monitors and must approve oversight of all Medicaid managed care operations.

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that DMA as the State Medicaid agency that contracts with MCOs and Prepaid Inpatient Health Plan (PIHP) submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. DMA assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review (EQR) of the outcomes, timeliness, and access to the services delivered under each MCO/ PIHP contract. To that end, DMA has a CMS-approved quality strategy and has contracted with two external vendors to conduct annual reviews of the MCO's Medicaid managed care operations.

Expansion of North Carolina's 1915 (b)/(c) Medicaid Waiver requires approval by CMS. Such approval allows each selected LME to develop a managed care delivery system to serve individuals with mental health, developmental disabilities and substance abuse needs who are eligible for Medicaid. Each LME operating as a MCO receives from Medicaid a capitation rate based on historical service utilization patterns for these populations.[2] The LME-MCO assumes financial risk for authorization and payment of required services for each Medicaid eligible individual. The functions of a LME-MCO include development of a provider network comprised of the most qualified providers, management of the network, authorization of services, coordination of care for individuals with the highest needs, and reimbursement of approved services. Both improved quality of care and cost effectiveness are brought about as a result of being able to: (1) select the most qualified providers for its network; and (2) coordinate recipient care in a manner that provides timely, appropriate services and prevents the need for more costly and intensive services.

DHHS solicited applications in February 2010 for LMEs to participate as Medicaid managed care vendors under the State's 1915 (b)/(c) Medicaid Waiver in addition to their state-funded responsibilities. Four LMEs applied and on the basis of the application process, the Department selected Mecklenburg County Area Mental Health, Developmental Disabilities, and Substance Abuse Authority and Western Highlands Network to be the next LMEs to participate as Medicaid managed care vendors under the State's Medicaid Waiver for mental health, developmental disabilities and substance abuse services.

S.L. 2011-264 instructed the Department to expand the 1915 (b)/(c) Medicaid Waiver statewide. The Department issued another request for applications and received seven applications from LMEs. The Department issued plans of correction to the other two LMEs (East Carolina Behavioral Health and Sandhills Center) that originally applied in 2010, and will work with them to begin managed care operations by April and July, 2012 respectively.

[2] Appendix B: Development of Capitation Rates

Based on the review of the LMEs' applications, the Department selected LMEs to manage Medicaid funded services as DMA contracted vendors through a capitated plan. DMA and DMH/DD/SAS will each contract with the selected LME-MCOs. Through the DMH/DD/SAS contract, LMEs will continue current obligations and commitment to the management of state and federally funded mental health, substance abuse and developmental disabilities services. Through the DMA contract, the LMEs will expand their roles and responsibilities as a LME-MCO. This creates a structure that integrates management of resources into one publically managed system that is more seamless and cost efficient.

LMEs that are selected must be fully operational by January 1, 2013. The Department will assign counties that remain uncommitted at that time to a fully operational LME/MCOs. Full expansion and DHHS assignment is expected to be completed by July 1, 2013.

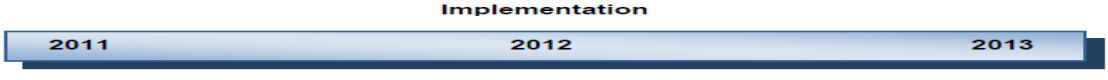
The State as Purchaser

The Divisions of MH/DD/SAS and Division of Medical Assistance (DMA) continue to define its role as a public purchaser of managed care services for citizens with mental health, developmental disabilities and substance use disorders. Contracting for care is a vehicle for introducing managed care into the public sector while responding to complex financial demands. The Divisions will translate rapidly evolving policy goals into effective Request For Proposals (RFPs) and contracts. "In a single generation, we have witnessed a major transformation of the public and private health insurance systems in the United States."[3] The difference between traditional public service systems and private sector methods of operation pose challenges to the Department. As the state and county mental health authorities move away from former roles as administrators of grants and contracts into new roles as purchasers, they must work within governmental limitations that are not found in the private sector. These include legislative and statutory restrictions, such as mandated services to special populations, restrictions on what type of providers can be utilized, set percentages of funding that must be spent in certain areas or for specified populations and underfunding. The Department is reorganizing its infrastructure to implement managed care principles and technologies necessary to manage the new system. While the challenges should not be underestimated, the role of purchaser will result in improved coordination of care, improve the predictability of costs, increase the accuracy of budgets, allocate limited financial resources more efficiently, and effectively expand coverage to a larger proportion of the population while increasing accountability for improving consumer outcomes.

LME Consolidation

The statewide expansion of the 1915(b)/(c) Waivers builds on the management functions and capacities of the LMEs to include the management of Medicaid resources within a managed care capitated environment. In order to be a successful managed care organization (MCO),

[3] Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers, SAMHSA 1998



LMEs need a sufficient number of covered lives to be financially stable. Therefore, S.L. 2011-264 required an increase in the population base to become a MCO which will ultimately result in mergers to meet the new population threshold. This consolidation, recommended by several studies, also will result in greater cost efficiency and administrative consistency.

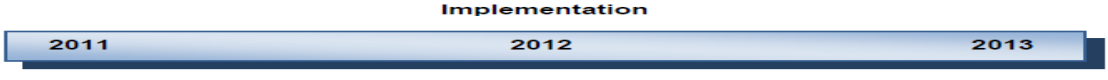
The LMEs have responded remarkably to the challenge of consolidation and the task of becoming an MCO. As noted earlier, seven applications were received in response to the April 1, 2011 the Department of Health and Human Services solicitation for applications from LMEs to become managed care organizations in a Medicaid waiver. These applications represented a consolidation from the current 23 LMEs to a potential 12. While the selection process is not yet complete, these consolidation efforts represent a tremendous commitment on the part of LMEs to move forward in a waiver environment and reflect considerable effort and partnership with stakeholders and county government. During the merger process and transition to LME-MCOs, LMEs will continue to provide minimally adequate services and remain financially sound as required per statute. The Department will work in partnership with the LMEs to review the process of these mergers to ensure their success.

Environmental Factors

The implementation of the 1915 (b)/(c) Waivers is taking place at a time of nationwide economic uncertainties, health care reform, and challenges in housing, job security, the role of government, political values, additional support for veterans, and scientific and medical developments.

The Secretary of DHHS is leading a Department wide strategic planning effort to respond to this changing environment resulting in the development of a uniform mission, vision and values and a strategic plan that is applicable to all of its divisions and offices, as well as goals and performance measures applicable to all services.

The Department's strategic plan includes key performance measures and targets to enable continuous monitoring and evaluation of progress toward the goals and objectives. These measures include budgetary information to enable review of costs and wise use of the resources available, especially in this time of economic hardship.



The Impact of the Patient Protection and Affordable Care Act (HR 3590) on the MH/DD/SA service system [4]

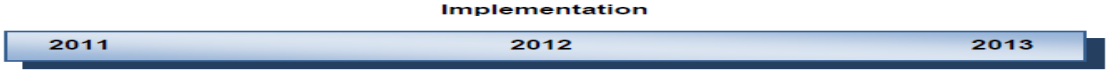
The Federal Patient Protection and Accountable Care Act seeks to ensure all Americans have access to quality, affordable health care to reduce long-term health care costs. With implementation it is estimated that over 500,000 North Carolinians will become eligible for Medicaid.[5] Key provisions of this legislation will have significant impact on those who receive services from the mental health, developmental disabilities and substance abuse service system. The provisions related to preventing the exclusion of individuals with pre-existing conditions from receiving insurance will apply to people with serious mental illness, developmental disabilities and a substance abuse diagnosis. There are also provisions in the legislation that provide for mental health and substance abuse parity and a voluntary public, long term care insurance program to help individuals with serious mental illness and those with functional limitations. Those who qualify would receive assistance to purchase services that will assist in their maintaining personal and financial independence. On the Medicaid front, the legislation calls for an increase in the number of people who will qualify for services when the poverty level calculation changes to 133% of the federal poverty level in January 2014.

With the passage of health care reform, Medicaid coverage will expand to include the health and behavioral health needs of a larger percentage of the population. In addition, the Affordable Care Act (ACA) promotes the integration of behavioral health and primary health care. This integration results in improved access and improved quality of services for those in need of mental health and substance abuse services. The goals for health care reform and North Carolina's expansion of the 1915 (b)/(c) Medicaid Waiver are similar in that they both focus on cost containment while focusing on increased quality, access, and prevention to improve care.

SAMHSA's Strategic Initiatives and Unified Plan

Another environmental factor affecting the public MH/DD/SA services system is the future use of funds from the federal Mental Health Block Grant (MHBG) and federal Substance Abuse Prevention/Treatment Block Grant (SAPTBG) provided to the State. The Substance Abuse and Mental Health Services Administration (SAMHSA) has committed to eight strategic initiatives in response to health care reform. These initiatives are more prescriptive in the use of MHBG and SAPTBG funds given the planning for the increased number of individuals who will be newly eligible for Medicaid in January 2014. Recognizing that states

[4] References: NAMI, 2010 , *Provisions in the Senate Passed Health Reform Legislation for Americans Living with Serious Mental Illness and Their Families*; and House Committee on Ways and Means, Energy and Commerce, and Education and Labor, March 23, 2010: *Affordable Health Care for America*, Summary.
[5] References: IOM, "Implementation of the Patient Protection and Affordable Care Act in North Carolina, Interim Report, March 2011, pg. 2



will play an important role in the design and implementation of health care reform and the need to be more strategic in purchasing services, SAMHSA set its strategic initiatives as:

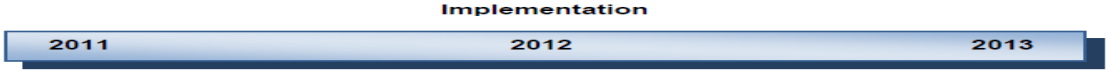
1. Prevention of Substance Abuse and Mental Illness.
2. Trauma and Justice.
3. Military Families.
4. Recovery Support.
5. Health Reform Implementation.
6. Health Information Technology.
7. Data, Outcomes, and Quality.
8. Public Awareness and Support.

In 2011, SAMHSA required each state to submit a unified block grant plan for SFYs 2012 and 2013, including both mental health and substance abuse funds for (1) individuals who are not eligible for Medicaid, (2) services that Medicaid does not cover, and (3) significant involvement in new data sharing and electronic health information. As required, the DMH/DD/SAS unified block grant plan includes new strategic priorities that focus on the SAMHSA initiatives and target populations including children and adults with mental or substance abuse disorders who are homeless, who are involved in criminal or juvenile justice systems, who live in rural areas, or who are in an underserved minority or lesbian/gay/bi-sexual/transgendered population, or communities with need for environmental prevention strategies and other prevention interventions, and recovery support services. One of the priorities in North Carolina's unified block grant plan is the statewide implementation of the 1915 (b)/(c) Medicaid Waivers and preparation for the Affordable Care Act (ACA) with designated LMEs operating as managed care organizations (MCOs).

As stated in Session Law 2011-261 (House Bill 916), the LME operating as a managed care organization (MCO) continues to be responsible for the management of "…all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice and all other public funding sources". One of the contractual requirements for an LME is to "prioritize State and non-Medicaid federal funds allocated for services under this contract for mental health, developmental disabilities and substance abuse services for severely disabled and economically disadvantaged individuals in the catchment area in accordance with DHHS Target Population categories."

Therefore, DMH/DD/SAS will continue to work with LMEs to ensure the appropriate use of federal block grant funds by LME-MCOs as required by SAMHSA and the State's block grant awards.

In summary, these environmental factors may bring considerable changes in the way mental health, developmental disabilities and substance abuse services are delivered, though the details of those changes are not yet known.



Chapter 2. Overview of the Strategic Implementation Plan

The strategic implementation plan is organized around a framework encompassing the State's vision for the Waiver initiative and goals that are designed to include and represent all stakeholders. The plan is based on an assessment of strengths and the challenges that lie ahead during the next two years. Included among those strengths is the commitment of the Department's leadership in facilitating the planning process and guiding DMH/DD/SAS and DMA in the development and implementation of the plan.

Goals for North Carolina

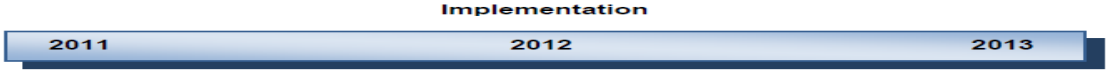
DHHS has six primary goals for the statewide expansion of the 1915 (b)/(c) Medicaid Waiver, including:

- Improve access to MH/DD/SA Services.
- Improve quality of MH/DD/SA Services.
- Improve outcomes for people receiving MH/DD/SA Services.
- Improve access to primary care for people with mental illness, developmental disabilities and substance abuse.
- Improve cost benefit of services.
- Effectively manage all public resources assigned to the MCOs.

The performance of the LMEs operating as a MCO under the 1915 (b)/(c) Medicaid Waiver will be measured over the long term to determine how well the strategy meets these primary goals for North Carolina.

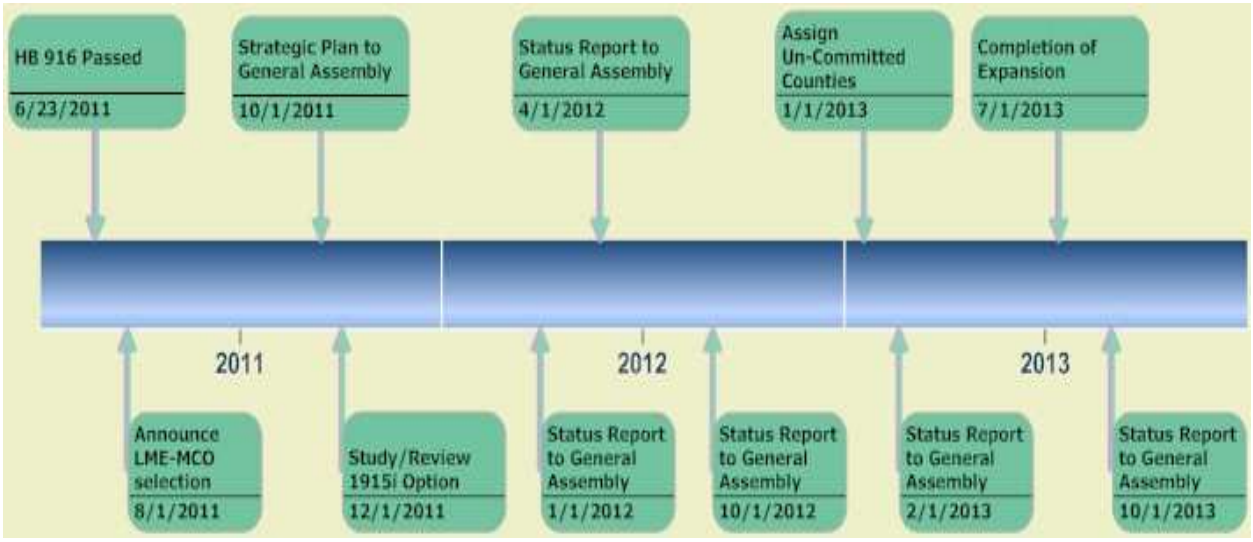
Purpose of the Strategic Implementation Plan

In addition to meeting the requirements of the North Carolina General Assembly for a strategic plan that delineates the specific strategies and agency responsibilities for the achievement of the objectives and deadlines as set forth in SL 2011-264 (House Bill 916), this strategic plan and its status reports provide a vehicle for active communication with all stakeholders across the State and for coordinating detailed implementation tasks among the Department, DMA, DMH/DD/SAS, LMEs, providers and consumers, and family members. This plan should be considered an initial plan that will evolve and be modified with time, experience, and stakeholder involvement.



Timeline

The strategic implementation plan includes specific strategic objectives to be accomplished within a given timeframe. Implementation of the strategic plan began July 1, 2011 and includes specific action steps that will be completed by July 1, 2013. Status reports will be provided to the Legislative Oversight Committee and published for all stakeholders as required by legislation. The following timeline depicts key implementation dates of the 1915 (b)/(c) Medicaid Waiver strategic plan.



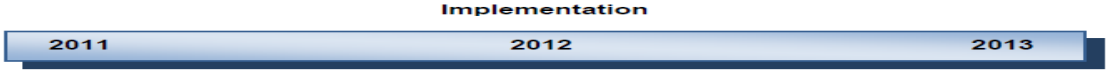
Implementation Structure and Process

The Department of Health and Human Services has focused on the importance of clearly identifying priorities and appropriate resources for the statewide implementation of the 1915 (b)/(c) Medicaid Waiver. The leadership of the Department believes that all stakeholders should have a clear and common perception of the State's priorities and confidence that these priorities are sound, given the state's changing needs and budget constraints.

Because the strategic plan impacts many, both outside as well as inside the organization, the Department acknowledges that these relationships must be utilized during various planning phases, including the communication of the strategic plan. Therefore, the process of developing this strategic plan has involved several phases.

- DMH/DD/SAS planning staff worked with Department leadership and waiver project managers from DMH/DD/SAS and DMA to develop a first draft of the plan with which stakeholders – both individually and as organizations - could provide input and feedback.
- The DMH/DD/SAS External Advisory Team including representatives from multiple stakeholder groups provided review and feedback.
- Representatives from the Council of Community Programs, representing the LMEs, provided review and feedback.
- The initial plan was posted on the web and distributed via a Communication Bulletin inviting all stakeholders to provide their ideas, suggestions, questions, and feedback.

This implementation plan should be considered as an initial plan that will evolve and be modified over time, experience, and continued stakeholder involvement until the implementation process is completed.



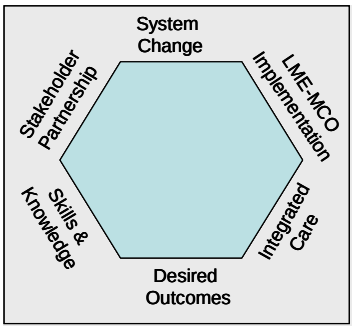
Chapter 3. Strategic Objectives and Action Steps

This strategic plan is organized into six strategic objectives. The objectives define the work that the Department, in partnership with the LME-MCOs and stakeholders, is committed to undertake between July 1, 2011 and June 30, 2013. The strategic objectives are:

- Oversee MH/DD/SA service system change
- Partner with LME-MCOs to Ensure Successful Implementation.
- Ensure access and quality of the service system for individuals with mental illness, developmental disabilities or substance abuse
- Strengthen the partnership with stakeholders in advising the State on implementation of the Strategic Plan.
- Increase knowledge and skills throughout the system.
- Partner with LME-MCO's and CCNC to promote and implement a system of integrated care between mental health, intellectual/developmental disability and substance abuse service providers and primary care providers.

These six objectives and strategies for their accomplishment are described in this chapter. Two or more action steps are identified as important for accomplishing each objective. Each action step has two or more activities to clarify the deliverables that must be accomplished and by when.

The Objectives Work Together



Successful implementation of North Carolina's 1915 (b)/(c) Medicaid Waiver statewide for the public MH/DD/SA system of services depends upon development of local management entities as managed care vendors with the careful oversight by the State and partnership with all stakeholders. Successful oversight of multiple system changes includes implementation of healthcare reform and changes in funding requirements of federal block grants that call for integrating care for individuals with the primary care system. The integration of primary care is dependent on increasing knowledge and skills throughout the system using multiple communication strategies and supporting learning communities. Greater knowledge and skills empowers individuals to advocate for improved outcomes for all individuals served.

Therefore, accomplishment of an action step under one objective may be dependent on the completion of other actions steps in the same objective or in another objective. The dates for

activities have been chosen to correspond to a necessary sequencing of related activities, plus recognition of limited resources for implementation at any one time. In addition, time has been allowed for engaging partners at the state level and at the local level including service recipients, LMEs, local governments, providers and other community agencies.

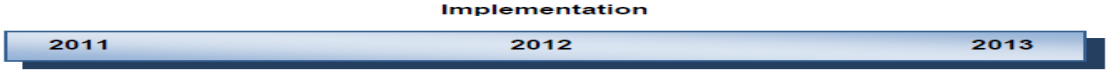
The Plan Requires Accountability

Progress will be measured in terms of the timely completion of the deliverables as defined in the action steps and activities. In addition, the overall effectiveness of these endeavors will be measured in terms of outcomes for consumers and changes in system performance over time. These are described in chapter 4.

It is important to recognize that a plan is a dynamic process and many variables, including financial limitations, changes in best practice, and business requirements, affect the outcomes. What is written in statute and rule outlines the specific authority of the Department, DMH/DD/SAS, DMA, LMEs, county governments, consumer and family advisory committees and providers. Beyond that, it is the Department's responsibility to provide policy guidance and tools for managing the system through performance and process expectations to ensure improved life outcomes for service recipients at State and local levels.

Researchers, practitioners, consumers, funding agencies and policymakers all seek to answer the question: Does the policy that has been designed and implemented to solve a problem actually solve that problem in the most cost-effective way possible? Most systems can and should routinely collect outcome data. The Department will implement a self-correcting system that is geared to identifying the effectiveness of matching system policy and practice, as well as consumers to specific services and supports. The Department will review aggregate information obtained through uniform measures across systems, programs and individuals to determine the degree of success among all interventions. These results when fed back to the system will be used to refine the systems and services to increase successful outcomes.

Ultimately, success rests with all stakeholders, including DMH/DD/SAS and DMA and the Department. With everyone's participation and commitment, the definition and accomplishment of the objectives will produce concrete, visible progress and changes for consumers and families within two years.

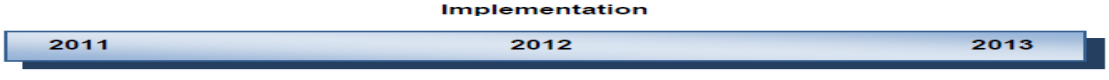


Objective 1: Oversee MH/DD/SA service system change

The Department's responsibility is to establish the long term vision and the means for achieving desired outcomes for the delivery and management of services for individuals with mental illness, substance abuse disorders or intellectual and/or developmental disabilities. The statewide implementation of the 1915 (b)/(c) Medicaid Waiver is the means to accomplish that vision, and the desired outcomes to create quality and stability in the system and predictability in the future. This involves a shift from managing processes to managing outcomes as the State determines how to affect system change. This objective points to the responsibilities of the State to manage system changes to accomplish the overall goals.

Action Step 1	**Publish strategic plan and status reports as required by SL 2011 (HB 916).**
Activities	
1. Complete	By 10/01/2011, DHHS will submit a strategic implementation plan to the NC General Assembly as required by HB 916 that includes LME-MCO and stakeholder input.
2.	By 01/01/2012, 04/01/2012, 10/01/2012, 02/01/2013, and 10/01/2013, DHHS will provide a status report of progress to the appropriate Oversight Committee of the NC General Assembly.
3.	By 01/01/2012, 04/01/2012, 10/01/2012, 02/01/2013, and 10/01/2013, DHHS will post to the DMA and DMH/DD/SAS websites a status report for stakeholder and public distribution.

Action Step 2	**Structure DHHS internally to provide statewide oversight of a locally managed system of MH, DD, and SA services through 1915 (b)/(c) Medicaid Waiver.**
Activities	
1. Complete	By 09/01/2011, DMA and DMHDDSAS will form and staff new Intra-departmental Monitoring Teams (IMT). (see Objective 2).
2. Complete	By 09/01/2011, DMHDDSAS will assign new functions to DMH/DD/SAS teams and/or existing matrix work groups and/or establish new matrix work groups as issues require, while maximizing use of clinically licensed and certified staff. These DMH/DD/SAS staff will join DMA staff on Intra-departmental Monitoring Teams.
3.	By 12/01/2011, DMH/DD/SAS will develop a training plan for DMHDDSAS staff to develop knowledge and skills to gain competency regarding waiver functions.
4.	By 01/01/2012, DHHS will identify and recruit leadership and expertise particularly in the areas of supported housing, I/DD, quality management, and system communication.



Action Step 3	Finalize selection of LMEs which will become Medicaid managed care vendors under the 1915(b)/(c) Waiver and assign uncommitted counties to existing LMEs.
Activities	
1. 8/1/11 Announce-ment Complete	By 08/01/2011, DHHS will announce the selection to date of LMEs to participate in the 1915 (b)/(c) Medicaid Waiver. By 11/07/2011, DHHS will announce all final selections.
2.	As required, DHHS will finalize and sign appropriate DMA contracts for each LME including (1) those selected as they become LME-MCOs, (2) those who currently operate as a LME-MCO.
3.	By 3/01/2012 and on an ongoing basis, DHHS will review and make recommendations for changes in statutes and/or rules pertaining to LME-MCO governance and other topics. (To include EMT, County Commissioners, LME-MCO, SCFAC, providers and other stakeholder involvement and feedback)
4.	By 07/01/2012 and on an ongoing basis, DHHS will facilitate LME mergers as part of implementation process. [to be defined more specifically at a later date]
5.	By 01/01/2013, DHHS will assign responsibility for uncommitted counties or those counties in which a LME application was not successful to existing LME-MCOs
6.	By 04/01/2013, DMA will secure CMS approval of amendments adding selected LMEs as Medicaid vendors under the 1915 (b)/(c) Medicaid Waiver.
7.	By 07/01/2013, DMA will confirm establishment of a statewide system of LME-MCOs participating under 1915 (b)/(c) Medicaid Waiver.

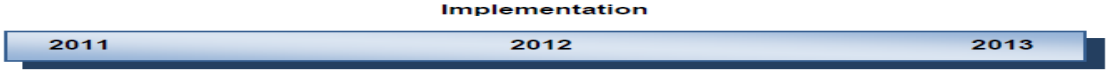
Action Step 4	Oversee implementation process of LME-MCOs Medicaid managed care duties and on-going state-funded duties.
Activities	
1.	By 10/01/2011, and quarterly thereafter, DMA and DMH/DD/SAS IMT staff will review implementation progress and make recommendations to EMT for changes in operations or monitoring of each LME-MCO.
2.	By 12/01/2011, DHHS will establish a DMA and DMH/DD/SAS Executive Management Team (EMT) with LME-MCOs and with stakeholder involvement to provide detailed oversight of the monitoring process and input for policy development for Medicaid and state-funded functions of LMEs-MCOs.
3.	By 01/01/2012, and annually thereafter, DMA will report progress and outcomes to CMS.
4.	Beginning by 01/01/2013, and on an ongoing basis, DMA and DMH/DD/SAS will review the trend of costs in the State Medicaid program (Innovations Waiver) and design strategies to deploy a system for allocation of resources based on the reliable assessment of intensity of need. (To include LME-MCO and stakeholder involvement and feedback).
5.	Beginning by 07/01/2013, and on an ongoing basis, the EMT will review recommendations for innovative changes in standardization of policies, procedures and/or forms for use by statewide by LME-MCOs.

Action Step 5	**Monitor the performance of the LME-MCOs in order to achieve specified consumer outcomes, system performance and cost benefits.**
Activities	
1.	By start date of operations each LME-MCO will successfully report encounter data to DMA Drive (for access by DHHS and CCNC networks) and the DMA actuaries and ensure that they resolve any state-funded reporting requirements. DMA will monitor each LME-MCO on this work plan step.
2.	By start date of Medicaid operations, DMA will ensure that the DMA/LME-MCO contract has identified consumer outcomes and system performance measures, as well as Performance Improvement Projects (PIPs) per the CMS Quality Framework and 42 CFR. The DMA will also work with LME-MCOs to ensure that identified PIPs also meet the requirements of the accrediting bodies mandated by DHHS, NCQA and URAC. Each LME-MCO will have valid reporting capabilities as evidenced through annual validation by the Medicaid External Quality Review (EQR)-vendor. DMA will monitor each LME-MCO on this work plan step.
3.	By 11/01/2011, DHHS will identify and conduct initial analysis of consumer outcomes and system performance measures during implementation and set schedule for periodic analysis including trends and pre- and post- comparisons.
4.	By 12/1/2011, DHHS will work in conjunction with LME-MCOs to define and begin conducting cost benefit analysis of the system during implementation and set schedule for periodic analysis.
5.	By 12/01/11, and every quarter thereafter, DMA and DMHDDSAS report results and trends to EMT.
6.	By 12/01/11, and every quarter thereafter, DMA and DMH/DD/SAS will review outcomes, system performance measures and cost benefit analysis and develop strategies and work in conjunction with LME-MCOs to address deficiencies.
7.	On an ongoing basis [with dates to be determined], DMA and DMH/DD/SAS will monitor LME-MCO risk management reserves and fiscal status.
8.	By 01/01/2012, DHHS will add new members, including DMH/DD/SA staff to the current DMA Continuous Quality Improvement (CQI) committee to review all DMA and DMHDDSAS contract performance measures.
9.	By 04/02/2012, DMA and DMH/DD/SAS will review outcome measures for both the DMA and DMHDDDSAS contracts and will include consumers, providers, LME-MCOs, and State facilities in the process.

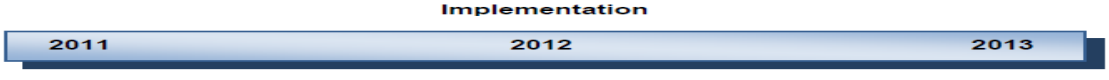
Objective 2: Partner with LME-MCOs to Ensure Successful Implementation

Through individual Intra-departmental Monitoring Teams (IMTs), the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services will monitor all Medicaid managed care operations and LME state-funded and block grant operations through the DMA and DMH/DD/SAS contracts respectively. Each Medicaid vendor (LME-MCO) will have a specific assigned IMT comprised of DMA and DMH/DD/SAS staff. DMA and DMH/DD/SAS will work with the LME-MCOs to correct any identified issues.

Action Step 1	**Establish the protocols and expectations for Intra-departmental Monitoring Teams (IMT).**
Activities	
1. Complete	By 09/01/2011, DMA with DMH/DD/SAS will set a schedule, assign staff, and establish an IMT for each selected LME-MCO.
2. Complete	By 10/01/2011, DHHS will establish protocols to assure consistency of operations across IMTs and establish means for communication among IMTs and requirements for reporting to the Executive Management Team (EMT).
3. Complete	By 10/01/2011, DMA with DMH/DD/SAS will initiate an IMT to monitor PBH expansion implementation plan.
4.	By 11/01/2011, DMH/DD/SAS will ensure monthly reporting to IMT from local Consumer and Family Advisory Committee (CFAC) to IMT.
5.	By 12/01/2011, DMH/DD/SAS will define procedures for monitoring cross-area service programs (CASPs) and use of block grant funding by LMEs
6.	By 12/01/11, and every quarter thereafter, DHHS will review outcomes, system performance measures and cost benefit analysis and create strategies to address deficiencies.



Action Step 2	Monitor the progress of each LME's implementation and readiness to become a LME-MCO.
Activities	
1. Initiated	By 10/01/2011, and monthly thereafter, DMA and DMH/DD/SAS will review and discuss progress of each LME –MCO according to their implementation plan Areas for review include: Medicaid managed care functions and merger/inter-local agreements. This information will be conveyed to the LME-MCO and correction plans will be established where needed.
2. Initiated	By 10/01/2011, and monthly thereafter, IMTs and LME-MCOs will assess implementation of standardized policies, protocols, and forms and identify recommendations for potential changes
3.	By 12/01/2011, IMTs will establish issues logs and will report progress, issues and concerns to EMT each month. EMT will review recommendations for changes.
4.	By 06/01/2012, as deemed necessary, DMA and DMH/DD/SAS will require plan of correction for LMEs for not meeting implementation plans, readiness reviews or other requirements for becoming a LME-MCO.
5.	By 07/01/2012, DMA and DMH/DD/SAS will schedule and/or hold two readiness reviews six months and three months prior to start date for each LME-MCO. IMTs will prepare appropriate plans of correction as needed and monitor progress in collaboration with LME-MCOs. DMA will oversee work of consultants, including on-site visits and formal reports.
6.	Six months after the start date for an LME-MCO, IMT will monitor quality indicators and outcomes on a quarterly basis and work with the individual LME-MCO to correct identified issues.

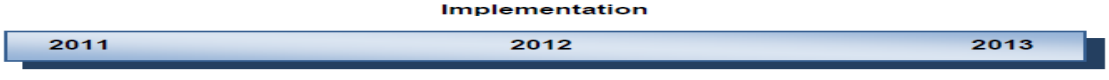


Objective 3: Ensure access and quality of the service system for individuals with mental illness, developmental disabilities or substance abuse

The Balanced Budget Act of 1997 requires states to implement quality assessment and performance improvement practices when entering into a contract with a managed care entity. These quality measures include availability of services, assurance of adequate capacity and services, coordination and continuity of care coverage and authorization of services, provider selection, enrollee information, confidentiality, and grievance systems.

The Divisions of Medical Assistance (DMA) and MH/DD/SAS will implement a monitoring process for LME-MCOs to meet performance measures related to the provision of timely access to high quality services within an integrated service system.

Action Step 1	**Ensure access and quality of the service system for consumers of mental health services and their families.**
Activities	
1.	By 011/01/2011, DMA, DMH/DD/SAS and LME-MCOs will develop strategies for outreach to encourage eligible individuals with mental health disorders to enroll in Medicaid.
2.	By 1/03/2012, and on an ongoing basis, IMT will review LME-MCO implementation plans and work with appropriate LME-MCO to develop capacity for serving eligible individuals with mental health disorders either through Medicaid or through services funded by State and federal dollars.
3.	By 01/03/2012, DHHS, in conjunction with LME-MCOs, will establish a process for receiving feedback and input from provider and consumer stakeholders on an ongoing basis.
4.	By 07/01/2013, DMA and DMH/DD/SAS will review LME-MCO strategies for mental health promotion and work with LME-MCOs on any identified issues.
5.	By 07/01/2013, DMA and DMH/DD/SAS will review LME-MCO plans and provide technical assistance to LME-MCOs to develop and implement a plan for strengthening recovery as an outcome of care for individuals with mental health disorders, families, and communities through Cross-Area Service Programs (CASPs) and Critical Access Behavioral Health Agencies (CABHAs) for the continued statewide development, support, and effective utilization of evidence-based treatment, recovery, and quality management practices.
6.	On an ongoing basis, DMA and DMH/DD/SAS will identify, promote, and assist LME-MCOs and their provider networks in the implementation of best practices in their networks. These best practices should identify, engage, and retain individuals with mental health conditions, achieve positive life outcomes, and promote and measure "recovery" as a service outcome.



Action Step 2	**Ensure access and quality of the service system for consumers of substance abuse services and their families.**
Activities	
1.	By 10/01/2011, and on quarterly basis, DMA and DMH/DD/SAS will monitor LME-MCO's design and promotion of best practices in their provider network and strategies that identify, engage and retain individuals with substance abuse in services.
2. Complete	By 10/01/2011, DMA, DMH/DD/SAS and LME-MCOs will promote the use of Screening, Brief Intervention, Referral and Treatment (SBIRT) and other tools by primary care physicians for the prevention and early intervention in cases of substance abuse.
3.	By 1/03/2012, and on an ongoing basis [with dates to be determined], IMT will monitor MCO's development of capacity for serving eligible individuals with substance abuse disorders either through Medicaid or through services funded by State and federal dollars and provide technical assistance as necessary.
4.	By 01/03/2012, DMA, DMH/DD/SAS, in conjunction with LME-MCOs and stakeholder groups, will establish a process for receiving feedback and input from stakeholders on an ongoing basis.
5.	By 01/01/2013, and on an ongoing basis, DMH/DD/SAS will monitor LME-MCO's prevention programs and environmental strategies to reduce the effects of substance abuse on adults and youth.
6.	By 01/01/2013, DMA, DMH/DD/SAS, in conjunction with LME-MCOs, will develop strategies for outreach to encourage eligible individuals with substance abuse disorders to enroll in Medicaid.
7.	By 07/01/2013, DMA, DMH/DD/SAS will review MCO plans and provide technical assistance to develop and implement a plan for strengthening Recovery Oriented Systems of Care (ROSC) for individuals with substance use disorders, families, and communities through CASPs and CABHAs for the continued statewide development, support, and effective utilization of evidence-based treatment, recovery, and quality management practices.
8.	On an ongoing basis, DMA and DMH/DD/SA will review specialty needs and populations and identify Best Practices, including new technology. Once identified, DMA and DMH/DD/SAS will work with LME-MCOs and providers to implement best practices.

Action Step 3	**Monitor MCOs to determine appropriate and timely access to community crisis services.**
Activities	
1.	By start date of Medicaid managed care operations, DMA and DMH/DD/SAS will develop contract performance measures for increased access to crisis or emergency services for individuals with MHSA or IDD or co-occurring primary care needs.
2.	By 07/01/2012, and on an ongoing basis, DMA and DMH/DD/SAS will work with LME-MCOs to monitor measures to evaluate use of and reductions in emergency department (ED) visits.
3.	On an ongoing basis, DHHS will work with LME-MCOs to promote prevention of inappropriate use of Emergency Department through pro-active crisis services and NC START Teams.

Action Step 4	**Monitor to assure increased access to habilitation services under the Innovation Waiver.**
Activities	
1.	By 10/01/2011, and annually there after a, IMTs will review each LME-MCO's gap analysis and plans to fill service gaps in the Medicaid and state-funded I/DD service array. .
2.	By 12/01/2011, DMA will contract with AAIDD for training and evaluation of a state wide Supports Intensity Scale (SIS).
3.	By 12/01/2011, and on an ongoing basis, IMTs will review the LME-MCO's identification, promotion, and barriers to community services and supports for individuals with I/DD to ensure self-determination.
4.	By 12/01/2011, DHHS will establish a process for the study/review of the 1915(i) Option.
5.	By 12/31/2011, DMH/DD/SAS' and DMA's will provide guidance and oversight of implementation of the Innovations Waiver, b3 services, and care coordination to ensure that the maximum number of individuals with IDD are served. The IMT will solicit LME-MCO and stakeholder input
6.	By 01/01//2012, and on an ongoing basis, IMTs will monitor the quality and utilization of Community Guide and care coordination in each LME-MCO network
7.	By 01/01/2012, and on an ongoing basis, LME-MCOs, in conjunction with DMH/DD/SAS and DMA, will monitor the provision of services to individuals with I/DD as required of G.S.131E-176 and G.S. 131E-178 and in accordance with CMS requirements.

Action Step 5	**DMH/DD/SAS and DMA to oversee process of transitioning individuals from the CAP-MR/DD Tiered Waiver to the Innovations Waiver.**
Activities	
1. Complete	By 09/01/2011, DMA and DMH/DD/SAS will develop a crosswalk between the CAP Waiver and the Innovations Waiver services and supports.
2.	By 11/01/2011, DMA will secure CMS approval of amended CAP-I/DD Waiver.
3.	By 11/01/2011, and on an ongoing basis, DMA and DMH/DD/SAS will ensure LME-MCO offers seminars for CAP Waiver providers to explain the service crosswalk within 90 days before the start date of each waiver site.
4.	By 12/01/2011, at the readiness reviews, and on an ongoing basis, DMA and DMH/DD/SAS will review LME-MCO infrastructure and expertise for management of I/DD services and supports in the Innovations Waiver.
5.	By 07/01/2013, will DHHS establish and implement a resource allocation plan (Supports Needs Matrix) based on the Supports Intensity Scale (SIS). Stakeholders will be involved in this process.

Action Step 6	**DMH/DD/SAS and DMA to monitor LME-MCO performance and individual outcomes of the Innovations Waiver.**
Activities	
1.	By 12/01/2011 DMA and DMH/DD/SAS will update all Innovations (c) Waiver performance measures and annually thereafter in conjunction with LME-MCOs. Both divisions will solicit feedback on performance measures from service recipients and families.
2.	By 11/30/2011, DMA and DMH/DD/SAS will develop state procedures for ongoing review and correlated reporting to verify the Innovations waitlist.
3.	By 01/01/2012, and on an ongoing basis, DMA and DMH/DD/SAS will ensure that each annual monitoring of the MCO includes review of all care coordination activities related to I/DD consumers.
4.	By 01/01/2012, DHHS will add new members, including DMH/DD/SA staff to the current DMA Continuous Quality Improvement (CQI) committee to review all Medicaid contract performance measures.
5.	By 07/01/2012, and on an ongoing basis, DMA and DMH/DD/SAS will collect and monitor their respective contract performance, and report to the legislature, and the public
6.	By 01/01/2013, DMA will amend DMA contract with annual oversight vendor (Mercer) to collect, validate, and prepare Innovations (c) Waiver annual quality report for CMS.

Action Step 7	**Manage the 1915(c) Innovations Waiver to achieve specified service outcomes, consumer outcomes, system performance and cost benefits.**
Activities	
1.	By 01/01/2012 or as soon as available, and on an ongoing basis, DMH/DD/SAS, in conjunction with LME-MCOs, will conduct analysis of Core Indicators to evaluate improvement in satisfaction.
2.	By 07/01/2012, and on an ongoing basis, IMT will review LME-MCO data to determine whether individuals with I/DD and co-occurring diagnosis have access to and receive appropriate comprehensive, person-centered services in their community
3.	By 07/01/2012, and on an ongoing basis, IMT will review LME-MCO data to determine whether individuals with I/DD and co-occurring diagnosis have access to and receive appropriate comprehensive, person-centered services in inpatient and facility-based settings.
4.	By 01/01/2013, DMA and DMH/DD/SAS, in conjunction with LME-MCOs, will establish statewide protocols to ensure access to services and ensure that the statewide waitlist identifies individuals in need of service and the service they are requesting.
5.	On an ongoing basis [with dates to be determined], DMA and DMH/DD/SA in consultation with and LME-MCOs, will review specialty needs and populations and identify Best Practices including, new technology. These will be conveyed to LME-MCOs and providers.
6.	On an ongoing basis [with dates to be determined], DMA and DMH/DD/SAS will utilize the readiness reviews to monitor the adequacy of the IDD infra-structure of the MCO.

Objective 4: Strengthen the partnership with stakeholders in advising the State on implementation of the Strategic Plan.

Stakeholder involvement is crucial to the successful implementation of the 1915 (b)/(c) Waivers. Successful LME-MCO applicants were required to demonstrate evidence of community stakeholder engagement (consumers and families, CFAC, provider network, community and county agencies) in submitting their application to the State. The emphasis on stakeholder involvement will continue at all levels from the LME-MCO through the DHHS level. It will include involvement in activities that review and formulate policy for waiver implementation and activities that monitor the LME-MCOs implementation and operation of the waivers.

Action Step 1	**Establish the roles and responsibilities for other stakeholders in the system.**
Activities	
1.	By 12/01/2011, DHHS will establish a process for DMH/DD/SAS and DMA to receive stakeholder feedback and input on elements of an effective customer service department for each LME-MCO.
2.	By 12/01/2011, and on an ongoing basis, DMH/DD/SAS and DMA staff will receive stakeholder feedback and input on elements of an effective care coordination department for each LME-MCO. This information will be reviewed and next steps will be determined in EMT.

Action Step 2	**Seek input regarding the understanding and satisfaction of consumers and families, advocates and providers with the implementation of LMEs becoming LME-MCOs.**
Activities	
1.	By 12/1/11, and every quarter thereafter, DMH/DD/SAS and DMA staff will review and address the questions, common concerns, comprehension, comments and satisfaction of all stakeholders and report to the EMT and LME-MCOs. EMT will review resolutions/responses.

Action Step 3	**Establish and maintain systems for consistent communication.**
Activities	
1.	By 12/01/2011, and on an ongoing basis, DMH/DD/SAS and DMA in collaboration with LME-MCOs and their County Commissioners will engage stakeholders in establishing and maintaining systems for ongoing, effective communication and coordination (DSS, DPH, DHSR, CCNC, hospitals, schools, academic centers, Department of Juvenile Justice, providers, and other state and community agencies).
2.	By 01/01/2012, DMA and DMH/DD/SAS will update their respective websites to publish quarterly dashboards of all LME-MCO performance measures, including annual consumer and provider surveys, service trends, performance improvement, and other outcome measures.

Objective 5: Increase knowledge and skills throughout the system

The implementation of the 1915(b)/(c) Waivers is a significant change in the MH/DD/SA service delivery system in NC. It is important that all stakeholders develop an understanding of these Medicaid Waivers. Knowledge enables the DHHS to assist the LME-MCO with successful implementation of the waivers. Knowledge and skills enable the LME-MCO to manage the system ensuring that individuals receive clinically indicated serves at the appropriate level. Knowledge assists the provider to utilize best practices to serve consumers. Knowledge empowers consumers to better advocate for their needs. Greater knowledge and skills among all stakeholders serves to improve outcomes.

Action Step 1	**Establish and maintain systems for consistent communication.**
Activities	
1. Initiated	By 09/01/2011, and on an ongoing basis, DMA and DMH/DD/SAS will prepare materials on the waiver for the general public and for LME-MCOs to use locally.
2.	By 10/01/2011, and on a quarterly basis IMT will review LME-MCO educational and collaborative activities with all stakeholders (service recipients, providers, local agencies) about the 1915 (b)/(c) Waiver to ensure activities occur and stakeholder feedback is received.
3.	By 12/01/2011, DHHS staff, in collaboration with LME-MCOs and their county governments, will begin to engage stakeholders in establishing and maintaining systems for ongoing, effective communication and coordination among state and local agencies and organizations
4.	By 01/01/2012, DHHS will enhance DMH/DD/SA, DMA, and DHHS websites to enable stakeholders, LME-MCOs, providers and consumers easy access to a full range of information regarding state and national health resources and initiatives.
5.	By 01/01/2012, DMH/DD/SAS, DMA and DHHS will develop a mechanism to monitor utilization of websites and seek feedback on the ease of the website's use as well as ideas on additional information or links that would enhance the website's utility.
6.	By 02/01/2012, and on an ongoing basis, IMT will review LME-MCO plans to facilitate the on-going exchange of information with employees of supports and services
7.	By 07/01/2012, and on an ongoing basis, DHHS will work with LME-MCOs to communicate system successes, lessons learned, and personal impacts on individuals to the general public.
8.	By 07/01/2012, DHHS and LME-MCOs will identify and promote system successes of the 1915 (b)/(c) Waiver on an on-going basis.
9.	On an on-going basis, DMH/DD/SAS and DMA staff will continue to collaborate with CFACs and other agencies representing individuals receiving services to identify and answer questions and concerns about system changes.

Action Step 2	**Ensure on-going learning and application of skills and knowledge.**
Activities	
1.	By 01/01/2012, and on an ongoing basis, DMA and DMHDDSAS will monitor their respective contract requirements and report LME-MCO recipient educational activities to each IMT.
2.	By 07/01/2012, DHHS, in conjunction with LME-MCOs, will develop model of a learning community and establish statewide networks to support learning and development opportunities for all stakeholders about 1915 (b)/(c) Waivers.
3.	By 07/01/2012, DHHS will develop a Consumer/Family Learning Academy.
4.	By 12/01/2012, and on an ongoing basis, IMTs will monitor LME-MCO's to ensure that each LME-MCO meets all CMS required standards for access to qualified services and professionals.

Objective 6: Partner with LME-MCO's and CCNC to promote and implement a system of integrated care between mental health, intellectual/developmental disability and substance abuse service providers and primary care providers.

Best practice and cost effective care require the integration of all of an individual's health care needs. There must be close communication between the primary care physician and the providers of MH, DD, and SA services. Community Care of North Carolina (CCNC) data indicates that 13.6% of the individuals served by their primary care physicians have significant (costing over $10,000 annually) behavioral health needs. It is crucial that all aspects of healthcare delivery to these, and all, individuals be coordinated to ensure the use of best practices, decrease duplication of services, and improve outcomes.

Action Step 1	**Provide outreach, support and services to individuals and families identified as being at risk of compromised health and safety to eliminate or reduce those risks.**
Activities	
1.	By 11/01/2011, and on an ongoing basis, DMA will require compliance with the LME-MCO's and CCNC's existing model of collaboration for the coordination of care for individuals with MI, IDD, and SA disorders.
2.	By 01/01/2012, DMA will ensure that all CCNCs and LMEs-MCOs performance contracts include requirements for collaboration, the support of integrated care practices and fidelity to the four quadrant integration of care model.
3.	By 02/01/2012, and on an ongoing basis, DMA will monitor the LME-MCO and CCNC networks to ensure that consumers have access to healthcare and behavioral health care treatment by integrating effective care management and care coordination, including strategies for promoting dental care.

Action Step 2	**Develop strategies and materials to educate/inform LMEs-MCOs, providers, consumers and family members, and other stakeholders of the four quadrant integration of care model in North Carolina.**
Activities	
1.	By 01/01/2012, and on an ongoing basis, DMA and DMH/DD/SAS will provide training to LMEs-MCOs, CCNC and providers, consumers, and other stakeholders regarding the Four Quadrant Integration of Care Model.
2.	By 01/01/2012, and on an ongoing basis, DMA will monitor LME-MCO's and CCNC networks' provision of educational opportunities and materials to inform and empowerment activities for consumers and families members regarding health care and integrated care.

Action Step 3	**Implement integrated care practices into MCO networks and review performance measures related to integrated care and collaboration.**
Activities	
1.	By 11/30/2011, DMA and DMH/DD/SAS will establish a system for monitoring indicators and publish this system for LME-MCOs and other stakeholders.
2.	By 01/01/2012, and on an ongoing basis, DMH/DD/SAS and DMA will evaluate State clinical policy and revise as needed to reflect new evidence and best practices of integrated care. Both Divisions will collaborate with LME-MCOs to implement those best practices in their local networks.
3.	By 04/01/2012, and on an ongoing basis, DMH/DD/SAS and DMA staff to assess the LME-MCO use of evidence-based practices in integrated care, e.g. SBIRT and modify as necessary to ensure fidelity and work with LME-MCO to strengthen practices where needed
4.	By 01/01/2013, and on an ongoing basis, IMTs will review outcomes and performance measures and, in conjunction with LME-MCOs, develop strategies to increase cost effectiveness.

Action Step 4	**Maximize use of consumer health information via CCNC Informatics System (Provider Portal)**
Activities	
1.	By 11/01/2011, DMA and DMHDDSAS staff to clarify qualification for access to Provider Portal/Informatics Center.
2.	By 01/01/2012, DMA and DMHDDSAS staff to clarify statewide general procedures and legalities for sharing data (HIPAA, HIT and electronic health records) on mental health, developmental disabilities, and substance abuse consumers.
3.	By 01/01/2012, DMA and DMHDDAS staff will collaborate with LME-MCOs to create and maintain data sharing protocols for providers to ensure informed treatment planning and coordination among providers.

Chapter 4. Evaluation of Progress and Next Steps

An important component of the Strategic Plan is the development and implementation of evaluation processes. The Department of Health and Human Services is presently engaged in several processes to ensure the appropriate evaluation of the system as the Medicaid Waiver is implemented. As stated in Chapter 2, the system's goals are to improve access to MHDDSA services, improve the quality of MH/DD/SA services, improve access to primary care for people with mental illness, developmental disabilities and substance abuse, improve cost benefit of services, and to manage all public resources assigned to the MCOs. Specifically, priorities for the evaluation process include determining that there is appropriate access to services both for those who are Medicaid-eligible, and for those who are indigent, evaluating the quality services that are provided to those who are served, auditing the utilization of fiscal resources for compliance with contractual requirements, and requiring corrective action when deficiencies in meeting performance expectations are found. The DHHS relies on a variety of mechanisms to evaluate the Waiver implementation process and ensure the quality of the service system.

External Quality Review (EQR)

External Quality Review (EQR), as mandated by CMS, consists of an extensive review of materials and processes that is conducted by an independent and certified EQR Organization to assess service delivery and coordination of health care provided by the MCO. This review culminates in an EQR Annual Technical Report submitted to DMA by the independent, certified EQR organization.

The Balanced Budget Act (BBA) of 1997 requires states to conduct an EQR process and requires DMA to implement quality assessment and performance improvement practices when entering into a contract with a Prepaid Inpatient Healthcare Plan (PIHP) or Medicaid Managed Care Organization (MCO). Title 42 Code of Federal Regulation (CFR) Part 438 outlines the State's responsibilities as they apply to the development, periodic review, and update of the State's Quality Strategy for assessing and improving the quality of managed care services provided by Medicaid managed care entities. As per Title 42 of the CFR, the State's Quality Strategy must be reviewed at least once every three years. The purpose of this assessment is to thoroughly review North Carolina's Quality Strategy and provide recommendations based on the standards provided in the Code of Federal Regulations. This goal is achieved through the following objectives:

1) Evaluate the implementation of the State Quality Strategy against CMS minimum standards.

2) Assess the effectiveness of CMS minimum strategies in improving care.

3) Identify opportunities for quality improvement using national benchmarks and quality measures.

4) Suggest enhancements to the State Quality Strategy in order to maximize the strategy's effectiveness.

The EQR staff works with DMA staff to gain an understanding of the goals, objectives, and purposes of the quality strategy as they relate to meeting both the requirements set forth in the CFR and DMA's extended needs. The approach is based on the requirements as outlined in the CFR, Title 42, Part 438, and a review of the following documents:

1) The Quality Strategy
2) The LME-MCO/DMA contract
3) Various supporting documents and reports submitted to DMA by the MCO

Using the CFR standards as a guide, the EQR will identify standards that apply to MCOs. For each standard, the EQR will review available evidence from the above data source documents to determine the extent to which the State, and its contractor MCOs, meet the standard. Quality measures data provided by MCOs in annual reports will be compared against the quality strategy and the standards. Interim reports and previous feedback received from CMS will also be utilized in the review of the quality strategy where applicable.

Intra-departmental Monitoring Teams

These teams, one for each LME-MCO, are comprised of DMA and DMHDDSAS staffs who meet monthly with representatives from their LME-MCOs to review progress toward a set of prescribed milestones in implementing their Waiver plan, adopting managed care functions, and continuing their LME responsibilities. Once the Waiver is implemented, each IMT will meet quarterly with its LME-MCO to assess its ongoing performance to ensure quality expectations are achieved and sustained. IMTs will receive regular reports from the LME-MCO, local CFAC and other recipients, and provider representatives. The IMTs will be the primary locus for reviewing the LME-MCO performance measures, making recommendations for improvements in each LME-MCO's operations, and monitoring their progress under both the DMA and DMHDDSAS contracts.

DMH/DD/SAS and DMA are currently working together to develop a cross-training and communication process for all staff assigned to the IMTs in order to ensure adherence to industry standards, identify and implement best practices and to nurture an internal quality improvement culture.

Annual on-site reviews

DHHS staff on the IMTs, in conjunction with national consultants, will conduct annual reviews of the LME-MCOs' operations. These onsite visits will serve to verify data reported to the State, provide an opportunity to observe LME-MCO operations, identify and discuss

ongoing issues with LME-MCO staff, and determine needed performance improvement projects.

Performance Measures

DMA and DMHDDSAS will employ a standardized set of performance measures to evaluate the progress of LME-MCOs as they assume the roles and responsibilities of managed care organizations and continue their current LME functions. These measures will include both comparative and trend data that the LME-MCOs report regularly to the State and data that the State compiles from administrative information. The State will use the performance measures to assist in monitoring managed care functions, as well as legislated functions required of LME to provide state and federally-funded services.

Some of the performance measures that will be used for the LME-MCO performance dashboard are required by the Centers for Medicaid and Medicare Services (CMS). Other performance measures are required by the Substance Abuse and Mental Health Services Administration (SAMHSA) for oversight of federal block grant funds. In addition, NC legislation requires performance measures to monitor LME operation of their legislated functions. The measures, including annual expectations for performance, will be specified in the LME-MCO contracts with DHHS. DMH/DD/SAS and DMA are currently reviewing current contracted performance measures to ensure that the federal and state requirements for each division are met, while simplifying and streamlining requirements for LME-MCOs.

The adopted measures will be based on definitions provided by HEDIS Technical Specifications, National Quality Forum Endorsed Standards, and other nationally accepted measures of healthcare quality. Examples of possible domains covered by the measures are included in the table below.

Domain	
• Access • System Performance & Financial Management • Consumer Experience • Integrated Care • Clinical Management	• Provider Networks • Stakeholder perceptions • Health and Safety • SAMHSA Initiatives • Prevention • Innovations

LME-MCOs and DHHS will begin tracking measures in these domains prior to becoming LME-MCOs so that baseline data is available. Then, service trends and fiscal viability can be monitored on an on-going basis. This will allow DHHS to monitor implementation as well as evaluate the impact of managed care on the existing service system.

As these data are collected and analyzed, the State will share results with providers, other LME-MCOs, partner agencies, and consumers and families. The State will also actively seek stakeholder input on an on-going basis as a vital component of the evaluation process.

As data are collected, the State will use the results to actively manage and monitor the waiver implementation process. Some measures will be used as "early warning signals" to alert the State of potential problems and assist LME-MCOs and the State in determining strategies to appropriately modify the implementation process. The DMH/DD/SAS, DMA and the LME-MCO will address areas of success and underperformance through the IMTs and other oversight committees described below to ensure that improvements are made and sustained.

Additional mechanisms that will be utilized to evaluate Waiver progress include the following:

- **Executive Management Team** – The Executive Management Team (EMT) will provide global oversight for waiver implementation. It will be comprised of staff from DHHS MCOs, and stakeholders. To ensure maximum stakeholder input, a stakeholder advisory committee will be established to include a wide range of interests. This group will designate members to serve on the EMT to communicate issues, concerns, and feedback.

- **Global Continuous Quality Improvement** – Led by DMA, per CMS requirements, and with DMH/DD/SAS membership, this committee reviews QMS activities and provides direction, feedback and support for strategic quality issues. It will also identify statewide trends in quality of care concerns. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for Medicaid participants.

- **DMH/DD/SAS Quality Improvement Steering Committee** – This committee acts as a clearinghouse for all state-funded and block grant efforts. It is responsible for evaluating the performance of the service system as a whole, reviewing issues identified by the above groups and other committees, develop plans for improvements, overseeing implementation of performance improvement projects, and evaluating the impact of improvement efforts.

In conjunction with the committees and processes listed above, periodic reports will be provided to the legislature and to the public to describe the status of LME-MCOs and waiver implementation.

Appendix A. House Bill 916

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

SESSION LAW 2011-264
HOUSE BILL 916

AN ACT TO ESTABLISH REQUIREMENTS FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND LOCAL MANAGEMENT ENTITIES WITH RESPECT TO STATEWIDE EXPANSION OF THE 1915(B)/(C) MEDICAID WAIVER.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services (Department) shall proceed with statewide restructuring of the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders through expansion of the 1915(b)/(c) Medicaid Waiver. It is the intent of the General Assembly that expansion of the 1915(b)/(c) Medicaid Waiver will be completed by July 1, 2013, and will result in the establishment of a system that is capable of managing all public resources that may become available for mental health, intellectual and developmental disabilities, and substance abuse services, including federal block grant funds, federal funding for Medicaid and Health Choice, and all other public funding sources. In implementing the restructuring and expansion authorized in this section, the Department shall do all of the following:

(1) Establish accountability for the development and management of a local system that ensures easy access to care, the availability and delivery of necessary services, and continuity of care for consumers in need of mental health, intellectual and developmental disabilities, and substance abuse services.
(2) Maintain fidelity to the Piedmont Behavioral Health (PBH) demonstration model, a proven system for the operation of all public resources for mental health, developmental disabilities, and substance abuse services.
(3) Designate a single entity to assume responsibility for all aspects of Waiver management. The following operational models are acceptable options for Local Management Entity (LME) applicants:
    a. Merger model: A single larger LME is formed from the merger of two or more LMEs.
    b. Interlocal agreement among LMEs: A single LME is identified as the leader for all Waiver operations, financial management, and accountability for performance measures.
(4) Use managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid program while ensuring medically necessary care and deploy a system for the

allocation of resources based on the reliable assessment of intensity of need. The Department shall design these strategies to efficiently direct consumers to appropriate services and to ensure that consumers receive no more and no less than the amount of services determined to be medically necessary and at the appropriate funding level.

(5) As the 1915(b)/(c) Medicaid Waiver expands statewide, phase out the current CAP-MR/DD Waiver as well as the utilization management functions currently performed by public and private contractors.

(6) Design the Innovations Waiver in such a way as to serve the maximum number of individuals with intellectual and developmental disabilities within aggregate funding.

(7) Require LMEs approved to operate a 1915(b)/(c) Medicaid Waiver of the following:

a. Maintain a local presence in order to respond to the unique needs and priorities of localities.

b. Implement a process for feedback end exchange of information and ideas to ensure communication with consumers, families, providers, and stakeholders regarding disability-specific and general Waiver operations.

c. Establish and maintain systems for ongoing communication and coordination regarding the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems such as local departments of social services, Community Care of North Carolina, hospitals, school systems, the Department of Juvenile Justice, and other community agencies.

d. Comply with the following operational requirements:

1. Maintain disability specific infrastructure and competency to address the clinical, treatment, rehabilitative, habilitative, and support needs of all disabilities covered by the 1915(b)/(c) Medicaid Waiver.

2. Maintain administrative and clinical functions, including requirements for customer service, quality management, due process, provider network development, information systems, financial reporting, and staffing.

3. Maintain full accountability for all aspects of Waiver operations and for meeting all contract requirements specified by the Department. The Department shall not require LMEs to subcontract any managed care functions or non-service activities to other entities. However, LMEs that choose to subcontract managed care functions to other entities will be limited to the following:

I. Information systems.

II. Customer service (including call center) operations.

III. Claims processing.

IV. Provider, enrollment, credentialing, and monitoring.

V. Professional services.

VI. Treatment Plan development.

VII. Referral to services.

SECTION 1.(b) By August 1, 2011, the Department shall select LMEs that have been assessed to meet minimum criteria for Waiver operations according to the requirements of RFA #2011-261 issued on April 1, 2011.

SECTION 1.(c) The Department shall require LMEs that have not been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver by January 1, 2013, to merge with or be aligned through an inter-local agreement with an LME that has been approved by the Department to operate a 1915(b)/(c) Medicaid Waiver. If any LME fails to comply with this requirement, the Department shall assign responsibility for management of the 1915(b)/(c) Medicaid Waiver on behalf of the noncompliant LME to an LME that is successfully operating the Waiver and successfully meeting performance requirements of the contract with the Department. Those LMEs approved to operate the 1915(b)/(c) Medicaid Waiver under an inter-local agreement must have a single LME entity designated as responsible for all aspects of Waiver operations and solely responsible for meeting contract requirements.

SECTION 1.(d) County governments are not financially liable for overspending or cost overruns associated with an area authority's operation of a 1915(b)/(c) Medicaid Waiver. County governments are not financially liable for overspending or cost overruns of Medicaid services associated with a county program or multicounty program's operation of a 1915(b)/(c) Medicaid Waiver beyond the county program or multicounty program's Medicaid risk reserve and Medicaid fund balance amounts.

SECTION 1.(e) Providers of targeted case management under the CAP-MR/DD Waiver are qualified to provide the 1915(c) service known as Community Guide under the Innovations Waiver. During the first year of assuming responsibility for Waiver operations, LMEs shall offer to contract with providers that were previously approved to provide targeted case management to individuals with intellectual and developmental disabilities under the CAP-MR/DD Waiver, for the provision of Community Guide services.

SECTION 1.(f) By December 31, 2011, the Department shall determine the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option as a strategy to address the needs of Medicaid enrollees with IDD who are not enrolled in the Innovations Waiver and are not residing in an intermediate care facility for the mentally retarded (ICF-MR facility).

SECTION 1.(g) The Department shall consider the impact on ICF-MR facilities included in the 1915(b)/(c) Medicaid Waiver to determine and, to the extent possible, minimize potential inconsistencies with the requirements of G.S. 131E-176 and G.S. 131E-178 without negatively impacting the viability and success of the 1915(b)/(c) Medicaid Waiver programs.

SECTION 1.(h) The Department shall discontinue the pilot program to administer the Supports Intensity Scale to people with intellectual and developmental disabilities in non-Waiver LMEs.

SECTION 1.(i) The Department shall establish written policies ensuring alignment of objectives and operational coordination of the 1915(b)/(c) Medicaid Waiver and the care of individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders with other organized systems under the auspices of the Department, including Community Care of North Carolina.

SECTION 1.(j) In the development of the budget for the 2013-2015 fiscal biennium and subsequent biennia, the General Assembly shall consider a reinvestment of at least fifteen percent (15%) of the total projected State savings for that biennium from the operation of the 1915(b)/(c) Waiver, for the purpose of expanding the number of consumers served by the Innovations 1915(c)

Medicaid Waiver, or for the purpose of expanding other services that are designed to meet the needs of individuals with intellectual and developmental disabilities.

SECTION 1.(k) By October 1, 2011, the Department, in coordination with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Medical Assistance, LMEs, PBH, and with stakeholder input, shall submit to the appropriate Oversight Committee of the General Assembly a strategic plan delineating specific strategies and agency responsibilities for the achievement of the objectives and deadlines set forth in this Act.

SECTION 1.(l) The Department shall submit status reports to the General Assembly on the restructuring and expansion authorized in this section on January 1, 2012, April 1, 2012, October 1, 2012, February 1, 2013, and October 1, 2013.

SECTION 2. G.S. 122C-115(a) reads as rewritten:

"(a) A county shall provide mental health, developmental disabilities, and substance abuse services through an area authority or through a county program established pursuant to G.S. 122C-115.1. The catchment area of an area authority or a county program shall contain either a minimum population of at least 200,000 or a minimum of six counties. Beginning July 1, 2012, the catchment area of an area authority or a county program shall contain a minimum population of at least 300,000. Beginning July 1, 2013, the catchment area of an area authority or a county program shall contain a minimum population of at least 500,000. To the extent this section conflicts with G.S. 153A-77(a), the provisions of G.S. 153A-77(a) control.

(a1) Effective July 1, 2007, the Department of Health and Human Services shall reduce by ten percent (10%) annually the administrative funding for LMEs that do not comply with the catchment area requirements of subsection (a) of this section. However, an LME that does not comply with the catchment area requirements because of a change in county membership shall have 12 months from the effective date of the change to comply with subsection (a) of this section. Effective July 1, 2012, the Department shall reduce the administrative funding for LMEs that do not comply with the minimum population requirement of 300,000 to a rate consistent with the funding rate provided to LMEs with a population of 300,000.

(a2) Effective July 1, 2013, the Department shall reassign management responsibilities for Medicaid funds and State funds away from LMEs that are not in compliance with the minimum population requirement of 500,000 to LMEs that are fully compliant with all catchment area requirements, including the minimum population requirements specified in this section.

(b) Counties shall and cities may appropriate funds for the support of programs that serve the catchment area, whether the programs are physically located within a single county or whether any facility housing a program is owned and operated by the city or county. Counties and cities may make appropriations for the purposes of this Chapter and may allocate for these purposes other revenues not restricted by law, and counties may fund them by levy of property taxes pursuant to G.S. 153A-149(c)(22).

(c) Except as authorized in G.S. 122C-115.1, within a catchment area designated in the business plan pursuant to G.S. 122C-115.2, a board of county commissioners or two or more boards of county commissioners jointly shall establish an area authority with the approval of the Secretary.

(d) Except as otherwise provided in this subsection, counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities or county programs because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority or county program. Counties may reduce county

appropriations by the amount previously appropriated by the county for one-time, nonrecurring special needs of the area authority or county program."

SECTION 3. G.S. 122C-115.3(a) reads as rewritten:

"(a) Whenever the board of commissioners of each county constituting an area authority determines that the area authority is not operating in the best interests of consumers, it may direct that the area authority be dissolved. In addition, whenever a board of commissioners of a county that is a member of an area authority determines that the area authority is not operating in the best interests of consumers of that county, it may withdraw from the area authority. An area authority that does not meet the minimum population requirements specified in G.S. 122C-115 may dissolve at any time during a fiscal year. Dissolution of an area authority or withdrawal from the area authority by a county for other reasons shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired."

SECTION 4. G.S. 150B-1(d) is amended by adding a new subdivision to read:

"(20) The Department of Health and Human Services in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs."

SECTION 5. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 13th day of June, 2011.

Walter H. Dalton
President of the Senate

Dale R. Folwell
Speaker Pro Tempore of the House of Representatives

Beverly E. Perdue
Governor

Approved 4:52 p.m. this 23rd day of June, 2011

Appendix B. Development of Capitation Rates

Initially, the rates will be calculated using a fee-for-service (FFS) data source. This will allow for the collection of managed care encounter and financial data for the first two years of the program. To develop capitation rates on an actuarially-sound basis for MCO using historical FFS data, the following general steps are performed:

1. Summarize the FFS Claims and Eligibility Data,
2. Combine the Multiple Years of FFS Data Together,
3. Project the FFS Base Data Forward,
4. Include the Effect of Program/Policy Changes, and
5. Adjust the FFS Data to Reflect Managed Care Principles.

The services that are covered under the capitation payments to MCOs are:

1. All Medicaid MH/DD/SA services described in clinical coverage policies 8A through 8J located on the DMA website at http://www.ncdhhs.gov/dma/mp/index.htm
2. Medicaid covered MH/DD/SA emergency room services, including all professional charges, x ray and lab work
3. All Medicaid covered services provided by psychiatrists
4. 1915(c) HCBS waiver services as defined in the "Innovations" Waiver at: http://www.ncdhhs.gov/dma/piedmont/InnovationsRenewal0408.pdf
5. Section 1915(b)(3) Waiver services as defined in the 1915(b) MH/DD/SAS Waiver.

To the extent that the pharmacy charges are included in a hospital bill, they are included in the rates. Labs for services provided outside of the ER are excluded.

Appendix C. LME-MCO Implementation Plan for IMT Oversight

As described in Objective 2, an Intra-departmental Monitoring Team (IMT) is assigned to oversee the implementation of an LME-MCO. Each LME develops its implementation plan and reports to the IMT on a monthly basis. The following describes the major tasks involved in establishing the functions that must be in place to operate as a managed care organization. Each implementation plan specifies target dates for these tasks based on a "go live" date upon DHHS and CMS approval.

1. **LME-MCO Facilities and Organizational Management Tasks**
2. **Contracting and Capitation**
3. **Customer Services**
4. **Utilization Management/Care Management**
5. **Innovations**
6. **Provider Network Management**
7. **CCNC & LME Engagement of Care Integration**
8. **Quality Management**
9. **Financial Management/Monitoring**
10. **Claims and IT Staffing**
11. **Claims Administration System Development**
12. **Provider Advisory Council and CFAC Representatives report out**
13. **Reporting**
14. **Merger / Inter- local Agreement Management/Monitoring**

Appendix D. Acronyms and Definitions

Acronyms

AAIDD	American Association of Intellectual Developmental Disabilities
CABHA	Critical Access Behavioral Health Agency
CFR	Code of Federal Regulations
CMS	The Federal Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/
DD or I/DD	Developmental disabilities or intellectual and/or developmental disabilities
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance, a division of DHHS and North Carolina's State Medicaid Agency
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities and Substance Abuse Services, a division of DHHS
EMT	Executive Management Team
EQRO	External Quality Review Organization
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act enacted by U.S. Congress in 1996
ICF-MR	Intermediate Care Facility for the Mentally Retarded
IMT	Intra-departmental Monitoring Team
MCO	Managed care organization
PBH	The LME formerly named Piedmont Behavioral HealthCare
PIHP	Prepaid Inpatient Health Plan – see below
PMPM	Per member per month
UM/UR	Utilization management / utilization review – see below

Definitions

Action	The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the LME to act within the timeframes provided in 42 C.F.R. 438.408(b). For a rural area resident with only one LME, the denial of a Medicaid Enrollee's request to obtain services outside the Provider Network: a. From any other provider in terms of training, experience, and specialization) not available in the network. b. From a provider not part of the network that is the main source of a service to the recipient—provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the Enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.

	c. Because the only plan or provider available does not provide the service because of moral or religious objections. d. Because the Enrollee's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
Appeal	A request for administrative review of an Action as defined above.
Grievance and Appeal Procedure	The written procedures pursuant to which Enrollees may express dissatisfaction with the provision of services by the LME and the methods for resolution of Enrollee grievances and appeals by the LME.
Critical Access Behavioral Health Agency	Critical Access Behavioral Health Agency (CABHA) is a new category of provider agency, approved by DHHS and CMS. CABHAs are designed to ensure that critical services are delivered by a clinically competent organization with appropriate medical, clinical, and quality management oversight and the ability to deliver a continuum of services.
Capitation Payment	A fixed payment remitted at regular intervals by DMA to the LME(s) operating a PIHP. The LME determines whether their providers are paid fee for service or on a capitated basis.
Care Management	A multidisciplinary, disease centered approach to managing medical care using outcome measures to identify best practices. The purpose of care management is to identify level of risk, stratify of services according to risk, and prioritize recipients for services. The approach utilizes collaboration of services, systematic measurement and reporting and resource management.
Clean Claim	A clean claim is a claim that can be processed without obtaining additional information from the provider of the services or from a third party. It does not include a claim under review for medical necessity, or a claim that is from a provider that is under investigation by a governmental agency for fraud or abuse.
Complaint	See grievance.
Covered Services	The services identified in the waiver application and in the contract that the LME agrees to manage pursuant to the terms of the contract.
Cultural Competency	The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of mental health, developmental disabilities and substance abuse services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to populations served; collaborate with the community regarding service provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

Days	Unless otherwise noted, refers to calendar days. "Working day" or "business day" means day on which DHHS is officially open to conduct its affairs.
Department	The North Carolina Department of Health and Human Services
Enrollee	A person who is on Medicaid and in one of the mandatory eligibility groups included in the waiver is automatically enrolled in the PIHP regardless of whether s/he ever accesses services.
Evidence based	A program or practice that has had multiple site random controlled trials demonstrating that the program or practice is effective for the population served.
Fee-for-service	A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to Recipients based on the payment methods set forth in the State Plan and the applicable policies and procedures of DMA.
Grievance	An expression of dissatisfaction by or on behalf of an Enrollee about any matter other than an action, as "action" is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the LME level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights).
Hearing	A formal proceeding before an Office of Administrative Hearing Law Judge in which parties affected by an action or an intended action of DHHS shall be allowed to present testimony, documentary evidence and argument as to why such action should or should not be taken.
Innovations Waiver	The current NC 1915 C home and community based services waiver (HCBS) currently operated by PBH and for which application has been made for statewide implementation. The Innovations Waiver replaces the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP-MR/DD) in the Piedmont counties.
Insolvency	The inability of the LME to pay its obligations.
Managed Care Organization (MCO)	An umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of providers, physicians and hospitals.
Medical Necessity	Treatment that is a. Necessary and appropriate for the prevention, diagnosis, palliative, curative, or restorative treatment of a mental health or substance abuse condition; b. Consistent with Medicaid policies and National or evidence based standards, North Carolina Department of Health and Human Services defined standards, or verified by independent clinical experts at the time the procedures, products and the services are provided;

	c. Provided in the most cost effective, least restrictive environment that is consistent with clinical standards of care; d. Not provided solely for the convenience of the recipient, recipient's family, custodian or provider; e. Not for experimental, investigational, unproven or solely cosmetic purposes; f. Furnished by or under the supervision of a practitioner licensed (as relevant) under State law in the specialty for which they are providing service and in accordance with Title 42 of the Code of Federal Regulations, the Medicaid State Plan, the North Carolina Administrative Code, Medicaid medical coverage policies, and other applicable Federal and state directives; g. Sufficient in amount, duration and scope to reasonably achieve their purpose, and h. Reasonably related to the diagnosis for which they are prescribed regarding type, intensity, duration of service and setting of treatment. Within the scope of the above guidelines, medically necessary treatment shall be designed to: a. Be provided in accordance with a person centered service plan which is based upon a comprehensive assessment, and developed in partnership with the individual (or in the case of a child, the child and the child's family or legal guardian) and the community team; b. Conform with any advanced medical directive the individual has prepared; c. Respond to the unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner; and d. Prevent the need for involuntary treatment or institutionalization.
Network Provider	A provider of mental health, developmental disabilities and substance abuse services that meets the LME's criteria for enrollment, credentialing and/or accreditation requirements and has signed a written agreement to provide services
Prepaid Inpatient Health Plan (PIHP)	An entity that 1) provides medical services to Enrollees under contract with the State Medicaid agency; 2) on the basis of prepaid capitation payments or other payment arrangements does not use State plan payment rates; 3) provides arranges for or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and 4) does not have a comprehensive risk contract.
Prior authorization	The act of authorizing specific services before they are rendered.
Provider	Any person, agency or entity providing mental health, developmental disabilities, or substance abuse services.

Provider Network	The agencies, professional groups, or professionals under contract to the LME that meet LME standards and that provide authorized Covered Services to eligible and enrolled persons
Recipient	An Enrollee who is receiving services.
Reconsideration	An enrollee's first step in the appeal process after an adverse organization determination; the LME-PIHP shall have procedures to reevaluate an adverse organization determination, findings upon which it was based, and any other evidence submitted or obtained.
Recovery	The processes, by which people are able to live, work, learn and participate fully in their communities.
Resilience	The personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses and to live productive lives.
Risk Contract	A contract under which the contractor: 1) assumes risk for the cost of the services covered under the contract; and 2) incurs loss if the cost of furnishing the services exceeds the payments under the contract. This contract is a risk contract because the LME assumes that risk that the cost of providing Covered Services to Enrollees may exceed the capitation rate paid by DHHS.
Risk Reserve	A restricted reserve account maintained by the LME to fund payments for outstanding obligations, such as cost overruns related to Medicaid program services.
Self-determination	Self-determination refers to the right of individuals to have full power over their own lives, regardless of presence of illness or disability. Self-determination in the mental health system refers to individuals' rights to direct their own services, to make the decisions concerning their health and well-being (with help from others of their choice, if desired), to be free from involuntary treatment, and to have meaningful leadership roles in the design, delivery, and evaluation of services and supports.
Service Management Record	A record of Enrollee demographics, authorizations, referrals, actions and services billed by Network Providers
Stakeholder	A person, group, organization, or system who affects or can be affected by an organization's actions.
State	The State of North Carolina
State Plan	The "State Plan" submitted under Title XIX of the Social Security Act, Medical Assistance Program for the State of North Carolina and approved by CMS
Subcontract	An agreement which is entered into by the LME in accordance with Section 11
Subcontractor	Any person or entity which has entered into a contract with the LME.

Third Party Resource	Any resource available to a Member for payment of expenses associated with the provision of Covered Services (other than those which are exempt under Title XIX of the Act), including but not limited to, insurers, tort-feasors, and worker's compensation plans
Utilization Management (UM)	A system's overall strategy for managing service utilization by individual clients and by the system as a whole. UM is implemented through a plan that combines care management, resource management, UR, and uses financial data to determine trends and service use patterns
Utilization Review (UR)	The process used to evaluate requested health care services and determine whether they are medically necessary
Waiver	The document by which DHHS, DMA, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients. Section 1915 (b) of the SSA authorized the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program. Section 1915 (c) of the SSA provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings as the Medicaid alternative to providing comprehensive long-term services in institutional settings. Initial waivers are approved for three years. Renewed waivers are granted for five years.